Testimony of Sue Levkoff, ScD, SM, MSW
To the Policy Committee of the White House Conference on Aging
What We Have Learned and Where We Need to Go: Future Directions for Mental Health Programming
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My name is Sue Levkoff. I represent the SAMHSA funded Positive Aging Resource Center, a member organization of the National Coalition on Mental Health and Aging. I am an Associate Professor in the Department of Psychiatry at Brigham and Women's Hospital and Harvard Medical School.

My remarks speak to What We Have Learned and Where We Need to Go: Future Directions for Mental Health Programming.

I will address three specific resolutions which the NCMHA has developed for submission to the 2005 White House Conference on Aging.

The first resolution I would like to address is that the White House Conference on Aging support the integration of older adult mental health and substance abuse services into primary health care and community based service systems. Recent research has supported the benefits of integrating medical and behavioral health service delivery for older adults, (Katon et al, 2002; Bartels et al, 2004). This has been accomplished through cross training, case management, consultation- liaison between mental health and primary care providers, or co-locating mental health and primary care providers in the primary care setting, (Katon et al, 1996; Unutzer et al, 2002; Bruce et al, 2004; Levkoff et al, 2004).

Some of the key components of primary care based mental health services include proactive patient screening and assessment, education and care management performed by a care manager to assess and educate the patient and to develop a care plan with the primary care provider, collaboration between primary care providers and mental health specialists in the supervision of the care manager, and clinician education and decision support for treatment, be it evidenced based algorithms for antidepressant medication management or psychotherapy.

Research has documented that collaborative care models that implement evidence-based changes at all levels of the primary care delivery system demonstrate the most impressive evidence in improving clinical outcomes for older adults with depression. This requires comprehensive changes in both internal organizational support (e.g., information technology, knowledge management strategies to support evidence-based practice) and external environmental support (e.g., community resources, public and private financial strategies, regulatory actions).

The second resolution I would like to address is that the White House Conference on Aging increase collaboration among aging, health, mental health and substance abuse consumer organizations, advocacy groups, professional associations, academic institutions, research entities, and all relevant governmental agencies to promote more

effective use of resources and to reduce fragmentation of services. Despite the breadth and availability of evidence-based practices for the treatment of mental health and substance abuse problems among older adults, a significant gap remains between the exiting knowledge base and its adoption into routine practice (Colenda et al., 2002). There is resistance to the implementation of evidence based practices by frontline service providers and program administrators as well as difficulties associated with their implementation.

The implementation of evidence-based practices across diverse service settings presents very specific challenges. Through our experiences in supporting EBP implementation through the SAMHSA Targeted Capacity Expansion Program, we found that service institutions differ greatly in their definition of what level of evidence is required to label a practice as evidence based, their readiness to adopt new evidence-based practices, and their capability to achieve financial and organizational sustainability of a new practice.

The existing MH/SA delivery systems, within their fragmented systems of care, do not work. The new system of care should focus on system integration, not cost reduction; coordination with primary care including training of primary care providers to recognize and treat mental health and substance abuse disorders, and coordination between primary and specialty care systems; treatment guidelines that are provider-friendly, and technical assistance for the adaptation of evidence based practices for specific sub-populations/ethnic minority groups. Current financing and reimbursement mechanisms must be revised to support the adoption of evidence based practices throughout the health care system.

State MH/SA and aging services organizations face formidable challenges in the implementation of EBPs. Years of separate funding streams for mental heath and substance abuse have created systems of care that are fragmented. This fragmentation is especially problematic for older adults with serious mental illness, who often deal with multiple and distinct care systems, including medical care, long-term care, mental health services, and aging network services.

Coordination and collaboration across state public health, behavioral health and medical systems and the larger network of aging services is crucial. Without this coordination, efforts to implement EBPs on a state-wide basis will remain fragmented. Consensus building and coordinated planning are necessary to reprioritize program agendas and reallocate resources crucial for successful implementation of evidence based practices into state-funded MH/SA service settings.

The third resolution I wish to address is that the 2005 White House Conference on Aging ensure that mental health and substance abuse services for older adults are age appropriate, culturally competent, and consumer-driven. The information is available; front line service providers need to be able to readily access, retrieve, and synthesize existing evidence in support of evidence based practices for treating mental health and substance abuse problems in older adults. These frontline services providers also need to have access to experts who can help them ensure that the evidence based practices they

choose to implement are culturally competent for the intended population. The needs of older adults from ethnic minority groups must be addressed, as such populations face special challenges in receiving culturally appropriate MH/SA services.

It is of vital importance that MH/SA services be consumer-driven. This means providing older adults with a meaningful choice of services, offered in different settings, and they be given the opportunity to participate in the care processes. Consumer-driven MH/SA services also require health education and prevention to reduce the prevailing stigma surrounding mental health problems; such services are also crucial for promoting positive aging. Existing consumer organizations such as OACHMA and the Mental Health Clearinghouse in Pennsylvania can provide needed input to ensure that services are consumer-driven.

I thank you for your consideration of these remarks. If I can provide any additional information, please do not hesitate to contact me at sue_levkoff@hms.harvard.edu.